STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 90162-001**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 22nd day of December 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 4, 2008, XXXXX, authorized representative of XXXXX ("Petitioner"), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on June 11, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan ("BCBSM") of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on June 20, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Individual Care Blue* certificate of coverage ("the certificate"), a PPO plan. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner enrolled for non-group coverage with BCBSM effective May 1, 2007. From

May through September 2007 he received Remicade as treatment for his ankylosing spondilytis. BCBSM denied coverage because it considered it to be for the treatment of a pre-existing condition and therefore excluded under the terms of the certificate.

The Petitioner appealed BCBSM's failure to cover his treatment. BCBSM held a managerial-level conference on March 24, 2008, and issued a final adverse determination dated April 11, 2008.

III
ISSUE

Is BCBSM required to pay for the Petitioner's Remicade treatment from May through September 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says:

> I called BCBS in February 2007 to get information on individual insurance plans. * * * Very specific details about my disease and my treatment were discussed at the time with one of [BCBSM's] agents on the phone. They were told about the Remicade treatments that I was currently taking. I was under the impression that I was going to be covered with [the BCBSM] policy. I was unaware of any waiting period at all. I first found out that there was a 6 month waiting period for anyone with a pre-existing condition that didn't choose COBRA after the second Remicade treatment was given to me in July 2007. I was never told of this. If that had been the case, I would have stuck with the COBRA, as they were able to cover my treatment. The reason I didn't take advantage of the COBRA was because of the cost.

The Petitioner believes that BCBSM should waive the pre-existing condition limitation in the certificate because he was given improper information by BCBSM.

BCBSM's Argument

BCBSM says that the certificate covers most benefits beginning on the effective date of the contract. However, hospital and physician services for pre-existing conditions are not covered during the first 180 days of coverage. The certificate says (page 1.6):

> Most benefits are available on the effective date of your contract. However, services for preexisting conditions (other than your prescription drug coverage…) are not covered during the first 180 days of your coverage, beginning on the enrollment date.
>
> The 180-day waiting period will not apply if:
>
> - You have creditable coverage and meet the following:
>
> -- There was not more than a 62-day break in your prior coverage
>
> -- You did not lose your prior coverage because of nonpayment of your premium or for fraud
>
> -- Your most recent coverage was with a group (even if the coverage was only for one day)
>
> **NOTE**: <u>If you were eligible for COBRA when your prior group coverage ended, you must have elected and exhausted COBRA coverage in order for your creditable coverage to eliminate the preexisting waiting period.</u> [Underlining added]

The certificate defines a preexisting condition as:

> A condition for which medical advice, diagnosis, care or treatment was recommended or received within the 180-day period ending on the enrollment date.

BCBSM believes that the Petitioner's Remicade infusion was for a preexisting condition and, since it is not in dispute that the treatment was received within 180 days after his nongroup coverage began on May 1, 2007, it is excluded from coverage.

BCBSM disputes the Petitioner's contention that he was misled or misinformed. BCBSM says that the application form for nongroup coverage contains this clear explanation:

> If you have a preexisting condition, there may be an initial 180-day waiting period from the start date of your coverage for which related claims may be reimbursable. You may be eligible to waive the pre-existing condition waiting period associated with BCBSM non-group coverage (including any limitation on pregnancy benefits) if you meet all of the following criteria:
>
> * * *
>
> - You have elected and exhausted any COBRA coverage for which you were eligible.

BCBSM argues that both the application form and certificate put the Petitioner on notice that there was a preexisting condition limitation for the first 180 days of coverage if he had not elected

and exhausted any COBRA coverage. BCBSM also says that at no time did it indicate to the Petitioner that the preexisting condition limitation would be waived.

Commissioner's Review

The certificate explains that treatment for a preexisting condition (other than prescription drugs)[1] is not covered during the first 180 days after the effective date of coverage, i.e., from May 1 through October 28, 2007. It is undisputed that the Petitioner had a preexisting condition (ankylosing spondilytis) that required treatment with Remicade. The Petitioner received Remicade treatment during the first 180 days after the start of his non-group coverage. Therefore, it was care for a preexisting condition and not a covered benefit according to the terms of the certificate.

Both the language of the certificate and the nongroup application form that the Petitioner was required to fill out explain that treatment for preexisting conditions is excluded for the first 180 days of coverage. The certificate and the application form also explain that the waiting period can be waived if COBRA coverage is elected and exhausted. The Petitioner acknowledged that he had not exhausted his COBRA coverage and BCBSM declined to waive the preexisting condition waiting period.

The Petitioner asserts that BCBSM misinformed him about his coverage; BCBSM disagrees. The Patient's Right to Independent Review Act ("PRIRA") does not allow the Commissioner to decide this kind of dispute. The PRIRA process lacks the hearing procedures necessary to make findings of fact based on oral statements. Moreover, even if it were possible on this record to assign fault for any miscommunication, the Commissioner is without authority to order equitable relief on that basis. Under PRIRA, the Commissioner's role here is limited to determining whether BCBSM has administered health care benefits under the terms and conditions of the applicable insurance contract and state law. The Commissioner finds that it did.

1 Remicade is a drug but it is an injectable drug that must be received through infusion. Injectable drugs are considered to be medical treatment and are covered in Section 4 of the certificate, "Coverage for Physicians and Other Professional Provider Services." The Petitioner's prescription drug plan (Section 6 of the certificate) covers medications obtained from a pharmacy. Injectable drugs must be ordered or furnished by a physician (see page 4.18 of the

The Commissioner finds that BCBSM correctly applied the terms and conditions of the Petitioner's certificate when it denied coverage for his Remicade treatment from May through September 2007 as treatment for a preexisting condition.

V
ORDER

BCBSM's final adverse determination of April 11, 2008, is upheld. BCBSM is not required to pay for the Petitioner's Remicade treatment for the first 180 days of his coverage since it was treatment for a preexisting condition and therefore not a covered benefit under the certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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certificate).